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| | 155727 | A. BUILDING _____ B. WING _____ | 03/16/2011 |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F0315 SS=D | Based on observation, interview, and record review, the facility failed ensure a resident who had a catheter was provided services to prevent urinary tract infections, in that Resident #22 experienced having a Foley catheter drainage bag and tubing held above the level of the bladder, for 1 of 1 residents reviewed for Foley catheters in the sample of 11.<br><br>Findings include:<br><br>Resident 22 was identified on the initial tour of the facility on 3/14/11, at 9:15 A.M., by the Medical Records Nurse, as having a Foley catheter, requiring assistance with activities of daily living, and being cognitively impaired.<br><br>The resident was observed on 3/14/11 at 9:15 A.M., lying in bed and had a Foley catheter.<br><br>The clinical record of Resident 22 was reviewed on 3/14/11 at 12:35 P.M.<br>The Resident's diagnoses included, but were not limited to, Urinary Tract Infection and Urinary Retention with outlet obstruction.<br><br>The admission MDS (minimum data set) assessment, dated 2/13/11, indicated the | F0315 | Resident # 22 no longer resides in this campus. Completion Date 4-12-2011All residents have the potential to be affected by the alleged deficient practice and therefore through corrective actions and in servicing the campus will ensure residents who have a foley catheter receive appropriate treatment and services to prevent urinary tract infections.Completion Date 4-12-2011All nursing staff has been in serviced on proper care of a foley catheter. Systemic change care givers will complete a competency "care of resident with a foley catheter" now and annually thereafter.Completion Date 4-12-2011DHS and/or designee will monitor compliance with observation of care audits on 2 residents per day with a foley catheter 5x a week x one month then weekly thereafterwith results forwarded to the QA committee for 6 months and quarterly thereafter for further review and suggestions/recommendations. Completion Date 4-12-2011 | 04/12/2011 |

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| | resident was frequently incontinent of urine, required assistance with activities of daily living, and was cognitively impaired.<br><br>A care plan problem, dated 2/14/11, indicated the resident was at risk for skin breakdown due to urinary incontinence and foley catheter. Approaches included, but were not limited to, "maintain drainage bag below the level of bladder."<br><br>A telephone physicians order dated 2/16/11 indicated a Foley catheter was ordered for the diagnosis of Urinary Retention with bladder obstruction.<br><br>On 03/15/11 at 1:15 P.M., LPN [Licensed Practical Nurse] #1 and CNA [Certified Nursing Assistant] #1 was observed to assist Resident #22 from the wheelchair to the bed. CNA #1 was holding the Foley catheter in her left hand above the level of the bladder.<br><br>On 03/15/11 at 1:20 P.M., CNA #1 was observed to place the Foley catheter drainage bag on top of a pillow and two folded blankets at foot of the bed allowing the drainage bag to be above the level of the bladder.<br><br>On 03/15/11 at 1:23 P.M. CNA #1 was | | | |

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| | observed to drain the Foley catheter tubing by holding the tubing up over the abdomen of Resident #22 allowing the tubing to be over allow the level of the bladder.<br><br>On 03/15/11 at 1:24 P.M. LPN #1 was heard saying to CNA #1, "I wouldn't have it up too high."<br><br>On 03/15/11 at 1:26 P.M. CNA #1 was observed to lay the Foley catheter tubing on the bed and the tubing was observed to immediately fill with urine.<br><br>The policy and procedure for catheter care provided by the DoN [Director of Nursing] on 03/16/11 at 9:00 A.M. indicated, "General Infection Control Guidelines 1. Observe (standard] universal precautions or other infection control standards as approved by appropriate facility committee."<br><br>During an interview with the DoN [Director of Nursing] on 03/16/11 at 10:00 A.M., she indicated, "there is no policy for keeping the foley catheter tubing and drainage bag below the level of the bladder, they just follow the CNA Core Curriculum guidelines." | | | |

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The Indiana State Department of Health, Core Curriculum, for Nurse Aide training, dated July 1998, included: " 5. The CNA's should: a. Keep drainage bag below level of bladder to allow gravity flow... e. Consider urinary drainage system whenever moving or transferring resident."

During an interview with CNA #2 on 03/15/11 at 3:35 P.M., she indicated it's important to keep the tubing and bag below the level of the bladder so the urine doesn't go back in."

During an interview with LPN #1 on 03/15/11 at 3:40 P.M. she indicated, "Foley catheter should not be so high, I wouldn't want it to flow back. Normally the CNA's would hook it on their [the CNA's] pants, but she was nervous."

During an interview with the DoN [Director of Nursing] on 03/16/11 at 9:45 A.M., she indicated, "The tubing and drainage bag should never be above the level of the bladder."

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| F0371 SS=F | Based on observation, interview and record review, the facility failed to ensure food was prepared and served in sanitary conditions, for 1 of 1 kitchens observed in the facility, in that the facility failed to follow the policy and procedure for monitoring food and dishwasher temperatures to ensure the safety of dishes and foods served, staff failed to ensure their hands were washed after handling dirty dishes and before touching clean dishes and staff did not know how to clean the juice dispenser. This had the potential to affect all 42 of 42 residents who reside within the facilities certified units and receive food from the kitchen. Resident A, B and C<br><br>Findings include:<br><br>1. During the initial tour of the kitchen on 3/14/11 at 9:00 A.M. Dietary Staff #1, was observed running dirty dishes through the dishwasher. She indicated the dishwasher used hot water to sanitize the dishes. She further indicated the temperature should reach 180 degrees during the rinse cycle. The load of silverware in the dishwasher at 9:00 A.M. had a temperature of 166 degrees on the rinse cycle, the cycle was repeated with the temperature of the rinse cycle reaching | F0371 | Resident A, B, and C, suffered no ill effects from the alleged deficient practice. Completion Date 4-12-2011All other residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure the campus prepares food and serves food in sanitary conditions.Completion Date 4-12-2011Dietary staff has been in serviced concerning the chemical sanitizer on the dish washing machine, hand washing, cleaning of the juice machine, food temperatures/thermometer calibration and log book recording. systemic change the dish machine has been fitted with a chemical sanitizer. Dietary personnel will complete hand washing competency now and annually thereafter. A cleaning log has been inititated to track the daily cleaning ofthe juice machine, an dietary staff #2 is no longer a cook.Completion Date 4-12-2011DFS/designee will monitor daily log book for chemical sanitation, food temperatures and juice machine cleaning log to assure in compliance. DFS/designee will also observe two random dietary staff preparing food or washing dishes to assure sanitation guidelines followed. These audits will be complete 5x a week for a month then 3x week for a month then weekly with results | 04/12/2011 |

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| | 174 degrees. The silverware was removed and placed to dry. A load of plates was then placed in the dishwasher with the rinse temperature reaching 174 degrees. The plates and silverware were observed to be stored for future use in the kitchen.<br><br>The maintenance supervisor entered the kitchen at 9:10 A.M. and indicated a mixing valve on the hot water heater was on order and had been causing the low temperatures. He indicated he checked the temperatures each morning and staff had been instructed to wait a few minutes between loads to ensure the rinse temperature reached 180 degrees.<br><br>Dietary staff #1 was asked for and provided a log of temperatures of the dishwasher, labeled "Daily Data Sheet," on 3/14/11 at 9:15 A.M. The form had areas for food temperatures for all three meals and dishwasher temperatures for all three meals. The back of the form had areas for sanitizer concentration in the sink and cleaning bucket.<br><br>The form for 3/14/11 indicated a documented rinse temperature of 180 degrees. The logs for 3/1/11 through 3/13/11, indicated the following with degrees in Fahrenheit: 3/1/11 only the | | forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 4-12-2011 | |

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| | breakfast temperature was documented with a rinse temperature of 175 degrees, no forms for 3/2 or 3/3 were provided, 3/4 and 3/5 were complete with all rinse temperatures 180 degrees or above, 3/6/11 documented the breakfast and lunch temperature as 200 degrees, supper temperatures were not documented, 3/7, 3/8. 3/9/11- lacked documentation of lunch or supper temperatures, 3/10 breakfast rinse was documented at 178 degrees, 3/11 breakfast rinse was 179 degrees, 3/12/11 breakfast was 168 degrees for the rinse temperature, with no other temperatures documented for lunch or supper from 3/10 to 3/12, 3/13, documented the breakfast temperature of 180 degrees for the rinse, no documentation was completed for lunch or supper.<br><br>The February 2011 dishwasher temperature log indicated 17 of the 24 days that were provided had a documented rinse temperature of below 180 degrees, 11 of the 24 days that were provided had at least one meal without documentation of the temperatures having been taken.<br><br>The policy and procedure, no date, provided on 3/15/11 at 10:00 A.M. by the facility administrator, for "Dish machine | | | |

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| | 155727 | A. BUILDING _____ B. WING _____ | 03/16/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| STONEBRIDGE HEALTH CAMPUS | 3100 SHAWNEE DR SOUTH BEDFORD, IN47421 |

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| | temperatures and sanitizer concentration will be accurately recorded to ensure proper sanitation of dishes and utensils," indicated "dish machine temperatures and sanitizer concentration will be recorded each meal...if the wash or rinse cycles temperature...do not meet the minimum requirements, the dining services manager will be notified...if the temperatures do not meet requirements, the cycle will be repeated and temperatures observed. If temperatures do not meet standards, corrective action will be taken...dish machine temperature and...logs and records of any corrective action will be kept on file..."<br><br>The dishwasher manufactures product information was provided on 3/16/11 at 10:00 A.M. by the maintenance supervisor, the policy indicated the temperature for the rinse cycle should be 180 degrees to 190 degrees for hot water sanitation to occur.<br><br>2. Dietary staff #3 was observed on 3/14/11 at 1:30 P.M. with a load of dishes in the dishwasher. Dietary staff #3 indicated the temperature of the rinse cycle was reaching "almost 180." The load of plates in the dishwasher was observed to have a wash temperature of 156 degrees and a final rinse temperature | | | |

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| | of 172 degrees, the plates were placed on the drying rack. Dietary staff #3 was observed to rinse dirty dishes, with no gloves or gown on, touching the dirty rack and dishes with her hands and uniform front. She was then observed to go take the clean plates and put them away. Dietary staff #3 was not observed to wash her hands between handling the dirty dishes and then the clean dishes while putting them away in the kitchen. Dietary staff #3 then washed her hands, handled the dirty dishes, placing them in racks and using the dishwasher, she then went to the clean side of the dishwashing area, touched clean dishes and put them in storage for future use in the kitchen. Dietary staff #3 was not observed to wash her hands between handling the dirty dishes and the clean dishes.<br><br>The policy and procedure for handwashing, no date, was received by the corporate dietary support person, on 3/16/11 at 10:45 a.m. indicated " employees will use proper hand washing techniques to prevent spread of infection...all hands are washed when entering the Nutrition Services Department...after handling soiled dishes and utensils..."<br><br>3. The facility was observed to have a | | | |

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| | juice dispenser in the dining room on 3/14/11 at 9:00 A.M. Dietary staff #2 and #1, on 3/14/11 at 10:00 A.M. indicated the machines were cleaned on the top and sides by the evening shift aide, and thought a company came in and cleaned the rest. Dietary staff # 4 indicated on 3/14/11 at 1:00 P.M. the evening shift aides cleaned the machines. Dietary staff #3, the evening aide, was interviewed on 3/14/11 at 1:30 p.m. indicated she washed the top of the machine, the drainage tray was brought into the kitchen and washed, and the sides washed down with the ends of the tubes where juice flowed down from the box wiped off.<br><br>The Cleaning and Preventative Maintenance policy provided on 3/15/11 at 10:00 A.M. by the Facility administrator. The policy indicated it had been faxed to the facility on 3/14/11 at 10:27 A.M. The policy indicated "daily: parts washing 1. Remove and wash the dispense nozzles, mixing elements, drip trays and drip tray cover in a mild detergent solution, rinse thoroughly. 2. wipe splash panel, areas around dispense nozzles, and refrigerated compartment with a clean, damp cloth."<br><br>During interview with the Dining Services Support employee, acting as the dietary | | | |

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| | manager, on 3/15/11 at 10:00 A.M., he indicated there was no documentation of dietary staff having cleaned the machine. He indicated he had taken the machine apart the day before and cleaned it. He further indicated the company who provided the machine serviced the machine. The facility administrator provided service records on 3/15/11 at 1:30 p.m. which indicated juice dispenser was serviced once each month, with the last service date of 2/25/11.<br><br>3. During the group meeting on 3/15/11 at 9:15 A.M. 2 of the 5 residents, Resident A and B, attending the group meeting indicated they had been served chicken that appeared raw at the Saturday evening meal on 3/12/11. During an interview with the family member of Resident C on 3/15/11 at 9:20 A.M., she indicated Resident C received a pureed diet, and she had not allowed her to receive the pureed chicken on 3/12/11 at the evening meal. She indicated other family members in the facility had came and told her the chicken served on the hall was not done. She indicated staff members soon came and took all the chicken off the trays and provided replacements. She indicated she could not tell if the pureed chicken was completely cooked or not but took no chances and did | | | |

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| | not allow her family member to consume it.<br><br>The week-end manager, LPN #5, the manager of the residential part of the facility, was interviewed on 3/14/11 at 1:00 P.M. She indicated the chicken served at approximately 5 P.M. at the Saturday evening on the hall trays appeared undercooked. She indicated she immediately stopped the chicken from being served to residents throughout the facility and provided replacements. LPN #5 indicated she and LPN #6 then checked the chicken on the steam tables for the dining rooms, she indicated the chicken on those lines appeared done and was then served out. During interview with LPN #6 on 3/16/11 at 10:30 A.M. she indicated she had pulled the chicken from all hall trays and provided replacements, this included the one pureed tray on the hall. LPN #6 indicated she checked all chicken on the buffet in the dining rooms and it appeared to be done. LPN #6 indicated she ate a piece to check and all seemed fine with it. LPN #6 indicated she did not know if a temperature had been obtained.<br><br>Dietary staff # 2 was interviewed on 3/15/11 at 9:00 A.M. she indicated the chicken had looked completely cooked to | | | |

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| | her. She indicated she took the temperature but could not remember what it was and did not record the temperature. Dietary staff #2 indicated she had used some of the chicken to make the purred chicken and it appeared to be done. Dietary staff #2 indicated the past dietary manager had been training her for two days to serve as a cook before she worked as the cook on 3/12/11.<br><br>The Corporate dietary services support person indicated on 3/15/11 at 10:00 A.M., he had been called about the chicken and arrived back at the facility on Sunday at 7:00 A.M. He further indicated he had changed the schedule to ensure only staff trained as cooks were cooking. He indicated Dietary staff #2 had not been trained to cook in the facility but was trained as a dietary aide to assist the cook.<br><br>Dietary staff #2's employee file was reviewed on 3/15/11 at 2:00 P.M. Dietary staff #2 was hired on 1/17/11. The job description indicated she was hired as a "dietary assistant." The jobs specific checklist was dated 1/20/11. The form indicated the staff member had not received instruction on all aspects of the assistant position, including the "food temperature record." | | | |

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| | Dietary staff #1 was asked for and provided a log of temperatures of the dish machine, labeled "Daily Data Sheet", on 3/14/11 at 9:15 A.M. The form had areas for food temperatures for all three meals and dish machine temperature for all three meals" The form dated 3/12/11, lacked documentation of any food temperatures having been taken at any of the three meals. The food temperatures for March 1 through the 13th, were lacking for at least one meal for 8 of the 22 days provided, 4 of 8 days lacked any temperatures for the entire day having been documented.<br><br>The policy and procedure, provided on 3/15/11 at 10:00 A.M. by the facility administrator, for temperatures, indicated "The temperature of all foods on the serving line will be measured and recorded at every meal...hot foods on the steam table are marinated at over 135 degrees Fahrenheit...."<br><br>This federal tag relates to Complaint IN00087611.<br><br>3.1-21(i)(1)<br>3.1-21(i)(2) | | | |

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| F0441 SS=D | Based on interview, observation and record review, the facility failed to ensure employees of the facility have a current tuberculosis skin test and/or chest x-ray for 1 of 8 employees reviewed for tuberculosis testing. Dietary Support Person<br><br>Findings include:<br><br>On 3/15/11 at 3:30 P.M., the Dining Service Support Person was observed in the kitchen to be preparing fruit trays for the evening meal.<br><br>On 3/15/11 at 4:00 P.M., the Dining Service Support Person's employee file was reviewed. The file lacked any documented PPD skin test since his hire date of 5/2/05.<br><br>In an interview with the Business Office Manager, on 3/15/11 at 4:30 P.M., she indicated she had contacted the Corporate Office, and she stated no one from the corporate office received an annual PPD.<br><br>The facility policy and procedure for TB Screening: HCW's [healthcare workers], no date, was provided by the Director of Nursing, on 3/16/11 at 9:15 A.M. The policy indicated "The goal of the one or two-step employee surveillance testing for | F0441 | The Dining Service Support employee now has a current TB skin test. No residents suffered any ill effects from the alleged deficient practice.Completion Date 4-12-2011All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure correct actions to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.Completion Date 4-12-2011Nurse Managers have been in serviced on TB skin test requirements. Systemic change the campus will keep a copy of southwest home office support employee's current TB skin test in a file in the business office. Completion Date 4-11-2011ED/designee will complete random audits of home office employees who visit the campus to ensure TB skin testing has been completed and is timely 5x week x one month then 3x a week x one month then weekly thereafter with results of compliance being forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 4-12-2011 | 04/12/2011 |

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| | tuberculosis annually and on hire, is to identify employees who are positive for active disease and to promote a living environment for residents and a work environment for staff that is free from contagious disease...Annually...Administer to PPD negative HCW's within the anniversary month of hire..."<br><br>3.1-14(t) | | | |

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| R0000 | This state residential finding is cited in accordance with 410 IAC 16.2-5. | R0000 | **The submission of this plan of correction does not indicate an admission by StoneBridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.The facility herby maintains it is in substantial compliance with the requirements of participation for residential health care facilities.To this end, this plan of correction shall serve as the credibel allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only.** | |

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| R0272 | Based on observation, interview and record review, the facility failed to ensure food was prepared and served in sanitary conditions, for 1 of 1 kitchens observed in the facility, in that the facility failed to follow the policy and procedure for monitoring food and dishwasher temperatures to ensure the safety of dishes and foods served, staff failed to ensure their hands were washed after handling dirty dishes and before touching clean dishes and staff did not know how to clean the juice dispenser. This had the potential to affect all 34 of 34 residents who reside within the facilities certified units and receive food from the kitchen.<br><br>Findings include:<br><br>1. During the initial tour of the kitchen on 3/14/11 at 9:00 A.M. Dietary Staff #1, was observed running dirty dishes through the dishwasher. She indicated the dishwasher used hot water to sanitize the dishes. She further indicated the temperature should reach 180 degrees during the rinse cycle. The load of silverware in the dishwasher at 9:00 A.M. had a temperature of 166 degrees on the rinse cycle, the cycle was repeated with the temperature of the rinse cycle reaching | R0272 | Resident A, B, and C, suffered no ill effects from the alleged deficint practice. Completion Date 4-12-2011All other residents have the potential to be affected by the deficient practice and through alterations in process and in servicing will ensure the campus prepares food and serves food in sanitary condition. Completion Date 4-12-2011Dietary staff has been in serviced concerning the chemical sanitizer on the dish washing machine, hand washing, cleaning of the juice machine, food temperatures/thermometer calibration and log book recording. Systemic change the dish machine has been fitted with a chemical sanitizer. Dietary personnel will complete hand washing cmopetency now and annually thereafter. A cleaning log has been inititated to track the daily cleaning of the juice machine, and Dietary staff # 2 is no longer a cook.Completion Date 4-12-2011DFS/designee will monitor daily log book for chemical sanitation, food temperatures, and juice machine cleaning log to assure in compliance. DFS/Designee will also observe two random dietary staff preparing food or washing dishes to assure sanitation guidelines followed. These audits will be complete 5x a week for a month then 3x week for a month then weekly with results forwarded to QA committee | 04/12/2011 |

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| STONEBRIDGE HEALTH CAMPUS | 3100 SHAWNEE DR SOUTH BEDFORD, IN47421 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | 174 degrees. The silverware was removed and placed to dry. A load of plates was then placed in the dishwasher with the rinse temperature reaching 174 degrees. The plates and silverware were observed to be stored for future use in the kitchen.<br><br>The maintenance supervisor entered the kitchen at 9:10 A.M. and indicated a mixing valve on the hot water heater was on order and had been causing the low temperatures. He indicated he checked the temperatures each morning and staff had been instructed to wait a few minutes between loads to ensure the rinse temperature reached 180 degrees.<br><br>Dietary staff #1 was asked for and provided a log of temperatures of the dishwasher, labeled "Daily Data Sheet," on 3/14/11 at 9:15 A.M. The form had areas for food temperatures for all three meals and dishwasher temperatures for all three meals. The back of the form had areas for sanitizer concentration in the sink and cleaning bucket.<br><br>The form for 3/14/11 indicated a documented rinse temperature of 180 degrees. The logs for 3/1/11 through 3/13/11, indicated the following with degrees in Fahrenheit: 3/1/11 only the | | monthly z 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 4-12-2011 | |

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| | breakfast temperature was documented with a rinse temperature of 175 degrees, no forms for 3/2 or 3/3 were provided, 3/4 and 3/5 were complete with all rinse temperatures 180 degrees or above, 3/6/11 documented the breakfast and lunch temperature as 200 degrees, supper temperatures were not documented, 3/7, 3/8. 3/9/11- lacked documentation of lunch or supper temperatures, 3/10 breakfast rinse was documented at 178 degrees, 3/11 breakfast rinse was 179 degrees, 3/12/11 breakfast was 168 degrees for the rinse temperature, with no other temperatures documented for lunch or supper from 3/10 to 3/12, 3/13, documented the breakfast temperature of 180 degrees for the rinse, no documentation was completed for lunch or supper.<br><br>The February 2011 dishwasher temperature log indicated 17 of the 24 days that were provided had a documented rinse temperature of below 180 degrees, 11 of the 24 days that were provided had at least one meal without documentation of the temperatures having been taken.<br><br>The policy and procedure, no date, provided on 3/15/11 at 10:00 A.M. by the facility administrator, for "Dish machine | | | |

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| | temperatures and sanitizer concentration will be accurately recorded to ensure proper sanitation of dishes and utensils," indicated "dish machine temperatures and sanitizer concentration will be recorded each meal...if the wash or rinse cycles temperature...do not meet the minimum requirements, the dining services manager will be notified...if the temperatures do not meet requirements, the cycle will be repeated and temperatures observed. If temperatures do not meet standards, corrective action will be taken...dish machine temperature and...logs and records of any corrective action will be kept on file..."<br><br>The dishwasher manufactures product information was provided on 3/16/11 at 10:00 A.M. by the maintenance supervisor, the policy indicated the temperature for the rinse cycle should be 180 degrees to 190 degrees for hot water sanitation to occur.<br><br>2. Dietary staff #3 was observed on 3/14/11 at 1:30 P.M. with a load of dishes in the dishwasher. Dietary staff #3 indicated the temperature of the rinse cycle was reaching "almost 180." The load of plates in the dishwasher was observed to have a wash temperature of 156 degrees and a final rinse temperature | | | |

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| | of 172 degrees, the plates were placed on the drying rack. Dietary staff #3 was observed to rinse dirty dishes, with no gloves or gown on, touching the dirty rack and dishes with her hands and uniform front. She was then observed to go take the clean plates and put them away. Dietary staff #3 was not observed to wash her hands between handling the dirty dishes and then the clean dishes while putting them away in the kitchen. Dietary staff #3 then washed her hands, handled the dirty dishes, placing them in racks and using the dishwasher, she then went to the clean side of the dishwashing area, touched clean dishes and put them in storage for future use in the kitchen. Dietary staff #3 was not observed to wash her hands between handling the dirty dishes and the clean dishes.<br><br>The policy and procedure for handwashing, no date, was received by the corporate dietary support person, on 3/16/11 at 10:45 a.m. indicated " employees will use proper hand washing techniques to prevent spread of infection...all hands are washed when entering the Nutrition Services Department...after handling soiled dishes and utensils..."<br><br>3. The facility was observed to have a | | | |

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| | juice dispenser in the dining room on 3/14/11 at 9:00 A.M. Dietary staff #2 and #1, on 3/14/11 at 10:00 A.M. indicated the machines were cleaned on the top and sides by the evening shift aide, and thought a company came in and cleaned the rest. Dietary staff # 4 indicated on 3/14/11 at 1:00 P.M. the evening shift aides cleaned the machines. Dietary staff #3, the evening aide, was interviewed on 3/14/11 at 1:30 p.m. indicated she washed the top of the machine, the drainage tray was brought into the kitchen and washed, and the sides washed down with the ends of the tubes where juice flowed down from the box wiped off.<br><br>The Cleaning and Preventative Maintenance policy provided on 3/15/11 at 10:00 A.M. by the Facility administrator. The policy indicated it had been faxed to the facility on 3/14/11 at 10:27 A.M. The policy indicated "daily: parts washing 1. Remove and wash the dispense nozzles, mixing elements, drip trays and drip tray cover in a mild detergent solution, rinse thoroughly. 2. wipe splash panel, areas around dispense nozzles, and refrigerated compartment with a clean, damp cloth."<br><br>During interview with the Dining Services Support employee, acting as the dietary | | | |

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| | manager, on 3/15/11 at 10:00 A.M., he indicated there was no documentation of dietary staff having cleaned the machine. He indicated he had taken the machine apart the day before and cleaned it. He further indicated the company who provided the machine serviced the machine. The facility administrator provided service records on 3/15/11 at 1:30 p.m. which indicated juice dispenser was serviced once each month, with the last service date of 2/25/11.<br><br>3. During the group meeting on 3/15/11 at 9:15 A.M. 2 of the 5 residents, Resident A and B, attending the group meeting indicated they had been served chicken that appeared raw at the Saturday evening meal on 3/12/11. During an interview with the family member of Resident C on 3/15/11 at 9:20 A.M., she indicated Resident C received a pureed diet, and she had not allowed her to receive the pureed chicken on 3/12/11 at the evening meal. She indicated other family members in the facility had came and told her the chicken served on the hall was not done. She indicated staff members soon came and took all the chicken off the trays and provided replacements. She indicated she could not tell if the pureed chicken was completely cooked or not but took no chances and did | | | |

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| | not allow her family member to consume it.<br><br>The week-end manager, LPN #5, the manager of the residential part of the facility, was interviewed on 3/14/11 at 1:00 P.M. She indicated the chicken served at approximately 5 P.M. at the Saturday evening on the hall trays appeared undercooked. She indicated she immediately stopped the chicken from being served to residents throughout the facility and provided replacements. LPN #5 indicated she and LPN #6 then checked the chicken on the steam tables for the dining rooms, she indicated the chicken on those lines appeared done and was then served out. During interview with LPN #6 on 3/16/11 at 10:30 A.M. she indicated she had pulled the chicken from all hall trays and provided replacements, this included the one pureed tray on the hall. LPN #6 indicated she checked all chicken on the buffet in the dining rooms and it appeared to be done. LPN #6 indicated she ate a piece to check and all seemed fine with it. LPN #6 indicated she did not know if a temperature had been obtained.<br><br>Dietary staff # 2 was interviewed on 3/15/11 at 9:00 A.M. she indicated the chicken had looked completely cooked to | | | |

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| | her. She indicated she took the temperature but could not remember what it was and did not record the temperature. Dietary staff #2 indicated she had used some of the chicken to make the purred chicken and it appeared to be done. Dietary staff #2 indicated the past dietary manager had been training her for two days to serve as a cook before she worked as the cook on 3/12/11.<br><br>The Corporate dietary services support person indicated on 3/15/11 at 10:00 A.M., he had been called about the chicken and arrived back at the facility on Sunday at 7:00 A.M. He further indicated he had changed the schedule to ensure only staff trained as cooks were cooking. He indicated Dietary staff #2 had not been trained to cook in the facility but was trained as a dietary aide to assist the cook.<br><br>Dietary staff #2's employee file was reviewed on 3/15/11 at 2:00 P.M. Dietary staff #2 was hired on 1/17/11. The job description indicated she was hired as a "dietary assistant." The jobs specific checklist was dated 1/20/11. The form indicated the staff member had not received instruction on all aspects of the assistant position, including the "food temperature record." | | | |

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| | Dietary staff #1 was asked for and provided a log of temperatures of the dish machine, labeled "Daily Data Sheet", on 3/14/11 at 9:15 A.M. The form had areas for food temperatures for all three meals and dish machine temperature for all three meals" The form dated 3/12/11, lacked documentation of any food temperatures having been taken at any of the three meals. The food temperatures for March 1 through the 13th, were lacking for at least one meal for 8 of the 22 days provided, 4 of 8 days lacked any temperatures for the entire day having been documented.<br><br>The policy and procedure, provided on 3/15/11 at 10:00 A.M. by the facility administrator, for temperatures, indicated "The temperature of all foods on the serving line will be measured and recorded at every meal...hot foods on the steam table are marinated at over 135 degrees Fahrenheit...."<br><br>This federal tag relates to Complaint IN00087611. | | | |